INSTRUCTIONS
FOR COMPLETING THE

IMPACT Plus Application for Eligibility

Please follow the instructions below, applying the instructions to each section as described. Fill in each section completely.

***Note*:** For region name, fill in the region that the recipient physically resides and the corresponding number.

At the top of each page, fill in the recipient's name and Medicaid number.

SECTION I – Demographic Information: Fill in the demographic information of the child on whom the application is being submitted.

SECTION II – Legal Guardian Information: Fill in the requested information on the child's legal guardian. This information is used by National Health Services (formally HRC) and Unisys to notify the legal guardian of application status.

SECTION III – Referral Source: Fill in the requested information on the person who referred the child for the IMPACT Plus Program. This information is used to identify the agency and/or behavioral health professional that has assessed the child could benefit from IMPACT Plus.

SECTION IV – IMPACT Plus Case Manager: Fill in the requested information on the case manager chosen to coordinate services for the applicant, if one has been selected by parent/guardian.

SECTION V - Placement/Custody History

Placement History: Focusing on the child's placement history, provide a complete history, including current placement, the last thirty (30) days, and the last 12 months (calendar year). This information assists in documenting "at risk of institutionalization" criteria.

Custody History: Complete this section if the applicant has any current involvement **or** a history of commitment with a state agency. If the applicant has a current state case worker, either because of state custody commitment or for supervision, provide the current information. This information assists in documenting "at risk of being in the custody of the state" criteria.

> **Current DCBS/DJJ Custody/Commitment:** Complete this section if the applicant has any current involvement with a state agency.
>
> **History of DCBS/DJJ Custody/Commitment:** Complete this section if the applicant has any past history of involvement with a state agency.
>
> **Reason for Commitment:** Complete this section regarding the applicant's current involvement with a state agency.

Check ONLY if voluntary or dependency: Complete this section regarding the applicant's current involvement with a state agency.

Current CPS/DCBS/DJJ Case Worker Name, Address, City, State, Zip, County, Work Phone, Emergency Phone: Complete this section with information regarding the child's current CPS/DCBS/DJJ Case worker.

Have the Parental Rights Been Terminated: Answer "Yes" or "No."

SECTION VI – Clinical Information

The clinical section provides a description of the severity of the applicant's DSM IV diagnosis, of how this diagnosis has effected the applicant over the past six months, of how the applicant is at risk of institutionalization, of how the applicant is at risk of being in the custody of the state, and how a coordinated and intense plan within the IMPACT Plus Program will benefit the applicant.

Diagnosis: Complete the DSM-IV information (Axis I – V), providing the most recent diagnosis. In addition, for each diagnosis, list the specific symptoms/behaviors that are related to the diagnosis.

Who diagnosed him/her: Fill in the behavioral health professional first and last name, credentials, and the agency of employment for him/her.

Phone: Fill in the phone number of the behavioral health professional who gave the last diagnosis.

When was the diagnosis given: Fill in the date the diagnosis was given.

Has the diagnosis changed over time: Answer "Yes" or "No." If the answer is "Yes," document how the diagnosis has changed over time. Provide specific information on previous diagnostic information, including the past diagnoses and when these were given.

If the current diagnosis was given recently (within a six-month time frame), use this section to document any previous diagnosis and why the behavioral health professional assessed the need to change the diagnosis. This section assists in documenting the severity of the applicant's diagnosis, specifically focusing on how the diagnosis has changed and increased in severity over time.

What has been the impact of the behaviors in relation to home, school, and community during the past six months: Provide a descriptive history in EACH area (Home – School – Community), focusing on the last six months. The documentation provided must describe six months of behavioral issues related to the diagnosis that have PERSISTED in each area. Provide specific dates or describe the frequency of each behavioral issue that occurred during the past six months.

The information requested is not a written behavior log; the information requested should describe how the behavior has negatively affected the home, school, and community of the applicant, ultimately leading to the applicant's

inability to function without intervention.

Describe how the above behaviors are at high risk for continuing for an additional six months: If interventions are not provided, illustrate how the home, school, and community issues will continue for an additional six months. If the applicant has an extended history of behavioral issues related back to his/her diagnosis, provide and describe specific examples from his/her extended history. Past behavior patterns can provide insight concerning how the applicant will continue to regress if intervention of services does not occur.

Describe the coordinated and intensive plan of all natural supports, community-based behavioral health services, including IMPACT Plus services: Based on the documented six-month history, identify the applicant's need(s), identify goals to address this/these need(s), identify the services that will meet the stated goals, and the length projected for the services to be provided. This plan should demonstrate how the anticipated services will successfully address the applicants needs. Focus on the use of all appropriate community-based services, including natural supports. Do not focus only on IMPACT Plus-paid services. An example would be to explain or describe how the applicant's school and educational services will participate in the plan.

Describe how a less intensive behavioral health service or program has been accessed and did not meet the recipient's treatment needs (provide information on behavioral health treatment history and/or current services, type of service (including medication administration), date of service, provider of service, and outcome): Document the applicant's previous treatment history, including medication administration, date(s) of service, provider(s) of service, and outcome(s).

Document how the above-described service(s) did not meet the applicant's need in the past and how these less intensive services are not appropriate to address the current needs. Appropriate non-traditional treatment services, including pastoral counseling and school interventions, should also be included in this description.

NOTE: If the applicant is not currently accessing or has not in the past accessed less intensive services, it may be more appropriate for the applicant to be referred to these services before making a referral to IMPACT Plus.

If an appropriate and less intensive behavioral health service or program has not been accessed, describe reasons why the service or program has not been accessed: Explain why a less intensive treatment resource has not been utilized. Include reasons the service may not be available within the applicant's community and/or the attempts made to obtain treatment that were not successful. This section should also include documentation of the applicant's co-occurring disorders, if any (Axis II and Axis III) that complicates the treatment needs, making a less intensive treatment resource inappropriate as a treatment option.

Prognosis: Describe the anticipated prognosis of the recipient after

receiving anticipated services: Describe how the applicant will benefit from receiving the identified services within the coordinated and intensive plan outlined previously. Focus the documentation on identifying and describing how the behavioral specific issues related to the diagnosis will be expected to decrease and show improvement over the course of a six-month treatment.

List any current medications and their purpose: Document the applicant's current medication, the purpose of the medication, the date the medication was initially prescribed, the prescribing physician's name and phone number. This information assists in documenting the applicant's six-month history and how current interventions, specifically medication, is utilized to meet current needs.

Discharge plan: Describe the anticipated discharge plan. Specify how services will transition from higher intensity services to lower intensity services. Describe the anticipated time frame. Describe the community based services and/or natural supports that will continue or be accessed at discharge: Please provide the specific information requested regarding the transition and discharge plan of the recipient.

Behavioral Health Professional Statement of Assessment: This section documents the involvement of a behavioral health professional, as required by regulation, and ensures that accurate assessment, treatment planning, and discharge planning have occurred while considering eligibility.

Additional comments: Provide any additional information that is not covered in the other above sections. Attach additional pages if necessary.

Release of Information: The parent/legal guardian is required to sign this application to ensure that proper authorization of the information documented has been received or agreed upon by parent/legal guardian. The signature also signifies the parent/legal guardian is agreeable to release the information to National Health Services (NHS) and other collaborative service agencies.

Eligibility Was Confirmed On:	
Case Management Agency Selected:	
Proximity of Case Manager to Child:	miles
Date of 1st Case Management Contact:	

IMPACT Plus Application for Eligibility

Region Name_____ **Region Number_____**

SECTION I – DEMOGRAPHIC INFORMATION			
Last Name	First Name		Middle Name
Medicaid Number **	Date of Birth (month, day, year) / /		Sex (*check one*) Male Female
Social Security Number	Phone ( )	Street Address	
City, State, Zip code			County

**In order to expedite the eligibility determination process, please include a photocopy of the child's Medicaid Card.

SECTION II – LEGAL GUARDIAN INFORMATION		
Circle the appropriate description: **PARENT** **RELATIVE** **DCBS** **DJJ**		
Last Name	First Name	
Street Address	City, State, Zip code	
County	Home Phone ( )	Work Phone ( )
Client living with guardian: YES NO	If "No", where is client residing: Contact person: Relationship: Address:	

SECTION III – REFERRAL SOURCE (*Agency/Behavioral Health Professional)*		
Last Name	First Name	Position/Agency:
Street Address	City, State, Zip code	
County	Phone ( )	Fax ( )
Date referred to Impact Plus / /	Date Submitted to HRC / /	

SECTION IV – IMPACT PLUS CASE MANAGER *(If one has been selected by the parent/guardian)*

Last Name	First Name	Agency
Street Address	City, State, Zip code	
County	Phone ( )	Fax ( )

SECTION V: PLACEMENT/CUSTODY HISTORY

IS RECIPIENT CURRENTLY IN CRISIS STABILIZATION?	IS RECIPIENT CURRENTLY IN THE HOSPITAL OR PRTF?
❑ YES ❑ NO	❑ YES ❑ NO

Most restrictive placement in last 30 days	**All** placements in the last calendar year (check all that apply)
❑ Jail ❑ Juvenile detention center ❑ Out of state residential facility ❑ Inpatient psychiatric hospital ❑ Drug/alcohol treatment center ❑ DJJ residential treatment center ❑ PRTF ❑ Private child care w/treat-oriented program ❑ Crisis stabilization ❑ Group emergency shelter ❑ Shelter program ❑ Group home ❑ Foster care ❑ Home of family friend ❑ Adoptive home ❑ Home of relative ❑ School dormitory ❑ Home of natural parent ❑ Independent living ❑ Homeless or "on the street" ❑ Other:	❑ Jail ❑ Juvenile detention center ❑ Out of state residential facility ❑ Inpatient psychiatric hospital ❑ Drug/alcohol treatment center ❑ DJJ residential treatment center ❑ PRTF ❑ Private child care w/treat-oriented program ❑ Crisis stabilization ❑ Group emergency shelter ❑ Shelter program ❑ Group home ❑ Foster care ❑ Home of family friend ❑ Adoptive home ❑ Home of relative ❑ School dormitory ❑ Home of natural parent ❑ Independent living ❑ Homeless or "on the street" ❑ **Other:**
Current Placement	Total Number of placements in last year

List ALL previous placements, beginning with the most recent (attach a separate sheet of paper if needed)

Date From	End Date	Placement Type/ Agency name	Outcome

CURRENT DCBS/DJJ CUSTODY/COMMITMENT STATUS ❑ DCBS ❑ DJJ ❑ NOT COMMITTED COMMITMENT DATE: ____/____/_____	HISTORY OF DCBS/DJJ CUSTODY/COMMITMENT STATUS ❑ DCBS ❑ DJJ ❑ NOT COMMITTED COMMITMENT DATE: ____/____/_____
REASON FOR COMMITMENT: (Check all that apply below) ❑ ABUSED/NEGLECTED ❑ DEPENDENCY ❑ STATUS OFFENSE ❑ PUBLIC OFFENDER ❑ VOLUNTARY ❑ NONE	Check ONLY if voluntary or dependency ❑ FAMILY STRESS/UNABLE TO COPE ❑ FAMILY MEMBER SAFETY ❑ LACK OF COMMUNITY RESOURCES ❑ PREVENTION OF STATUS ❑ LACK OF FAMILY FINANCIAL RESOURCES ❑ OTHER: _____
CURRENT CPS/DCBS/DJJ CASE WORKER NAME	STREET ADDRESS
CITY, STATE, ZIP CODE	COUNTY
WORK PHONE	EMERGENCY PHONE
HAVE THE PARENTAL RIGHTS BEEN TERMINATED? ❑ YES ❑ NO	

SECTION VI: CLINICAL INFORMATION

Axis I Diagnosis: _____ _____ _____ _____ _____ _____	Symptoms/Behaviors of Axis I Diagnosis _____ _____ _____ _____ _____ _____
Axis II Diagnosis: _____ _____ _____ _____ _____ _____	Symptoms/Behaviors of Axis II Diagnosis _____ _____ _____ _____ _____ _____
Axis III Diagnosis: _____ _____ _____	Impact of medical condition _____ _____ _____
Axis IV Severity: ❑ Mild ❑ Moderate ❑ Severe	Affected Domains of Functioning *(Check all that apply):* ❑ Primary Support Group/Social Environment ❑ Economic ❑ Housing ❑ Educational ❑ Access to Health Care ❑ Occupational ❑ Legal/Criminal

Clinical information, continued

Axis V: GAF Score: _____	Symptoms: _____ _____ _____ ___
Who diagnosed him/her? (Clinician, Credentials and Agency)	
Phone ( )	When was the diagnosis given? / /

Has the diagnosis changed over time?

- ❑ YES
- ❑ NO

If YES, how? (Please list previous diagnoses as well)

_____

_____

_____

_____

_____

What has been the impact of the behaviors in relation to home, school and community during the past six months? **(Be specific, if the impact is "aggressive", describe the aggressive behaviors in detail)**

HOME: Please describe the family dynamics. Specifically, how has the parent/guardian and family responded to the child's acting out behaviors.

SCHOOL:

COMMUNITY:

Describe how the above behaviors are at high risk for continuing for an additional six (6) months (Assessment must have been completed by a Behavioral Health Professional)

Describe the coordinated and intensive plan of all natural supports, community-based behavioral health services, including IMPACT Plus services:

Identified need	Goals to address need	Potential services to meet identified needs (include natural supports as well as services)	Duration

Describe how a less intensive behavioral health service or program has been accessed and did not meet the recipient's treatment needs (provide information on behavioral health treatment history and/or current services, type of service (including medication administration), date of service, provider of service, and outcome)

_____
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If an appropriate and less intensive behavioral health service or program has not been accessed, describe reasons why the service or program has not been accessed

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Prognosis: Describe the anticipated prognosis of the recipient after receiving anticipated services

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_____

List any current medications and their purpose:

Medication / Dosage/Frequency	Purpose	Date Initially Prescribed	Physician	Phone

Discharge plan: Describe the anticipated discharge plan. Specify how services will transition from higher intensity services to lower intensity services. Describe the anticipated time frame. Describe the community based services and/or natural supports that will continue or be accessed at discharge

_____
_____
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_____

Behavioral Health Professional Statement of Assessment:
The signature of the Behavioral Health Profession certifies that an assessment has been completed and the above documentation outlines specifics regarding treatment needs, how to address the identified treatment needs, and anticipated outcomes of service provision.

Behavioral Health Professional Name	Behavioral Health Professional Signature	Discipline and License Number	Date of Signature

ADDITIONAL COMMENTS

Completed applications must be submitted to:

National Health Services
9200 Shelbyville Road, Suite 800
Louisville, KY 40222
Attention: IMPACT Plus
OR
FAX: 800-807-8843

For additional program information, please visit our website http://mhmr.chs.ky.gov/mh/impact_plus

Parent/Legal Guardian Release of Information

I recognize that my child's condition may require the collaboration of numerous agencies and service providers. I understand that this collaboration requires the disclosure of information about my child and our family to assist the various service providers to make necessary assessments and care plans.

I hereby authorize the release of the information specified below to the National Health Services (NHS), Case Manager, designated Service Provider agency for Case Management and/or Impact Plus Program Staff. The information will be used in connection with the assessment of the child herein named, and may be disclosed to any person participating in Collaborative Service Team meeting process. The information shall not be otherwise released and shall be held confidential for any other purposes.

I understand that the information obtained will become part of the application for referral of the above-named child and does not guarantee that services will be provided. This information will be used to determine eligibility for IMPACT Plus and, if my child is accepted into the program then this information can be used to formulate a Collaborate Care Plan on the child's behalf. I have read, or have had explained to me, the above authorization and fully understand it. I have also been provided with a completed copy of this application. This release is valid for up to one (1) year from the date of my signature.

Signature: _____ Date: _____

Relationship to child: (check one)

___Parent ___Guardian ___Other _____
(Relationship)

Child's Signature: _____ Date: _____

Child's signature is strongly encouraged for all participants. Child's signature is required when alcohol or substance abuse records are involved, or when the court system is involved.

Witness: _____ Date: _____

IMPORTANT: Signatures must be witnessed